First Health Services Corporation
A Coventry Health Care Company

Drug Application Subsystem

VaMMIS Procedure Manual

Version 1.0

June 11, 2008

HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] provides protection for personal health information. The regulations became effective April 14, 2003. First Health Services developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandated.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Document Version	Date	Name	Comments
1.0	12/12/07	Donna P. Johnson, Documentation Mgmt. Team	Creation of document

Table of Contents

Preface

The Procedures Manual for the Virginia Medicaid Management Information System (VaMMIS) is a product of First Health Services Corporation. Individual manuals comprise the series of documents developed for the operational areas of the VaMMIS project. Each document includes an introduction, a functional overview of the operations area, workflow diagrams illustrating the processing required to accomplish each task, and descriptions of relevant inputs and outputs. Where appropriate, decision tables, lists, equipment operating instructions, etc. are presented as exhibits, which can be photocopied and posted at unit workstations. Relevant appendices containing information too complex and/or lengthy to be presented within a document section are included at the end of the document.

Use and Maintenance of this Manual

The procedures contained in this manual define day-to-day tasks and activities for the specified operations area(s). These procedures are based on First Health's basic MMIS Operating System modified by the specific constraints and requirements of the Virginia MMIS operating environment. They can be used for training as well as a source of reference for resolution of daily problems and issues encountered.

The unit manager is responsible for maintaining the manual such that its contents are current and useful at all times. A hardcopy of the manual is retained in the unit for reference and documentation purposes. The manual is also available on-line for quick reference, and users are encouraged to use the on-line manual. Both management and supervisory staff are responsible for ensuring that all operating personnel adhere to the policies and procedures outlined in this manual.

Manual Revisions

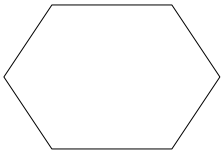
The unit manager and supervisory staff review the manual once each quarter. Review results are recorded on the Manual Review and Update Log maintained in this section of the document. Based on this review, the unit manager and supervisory staff determine what changes, if any, are necessary. The unit manager makes revisions as applicable, and submits them to the Executive Account Manager for review and approval. All changes must be approved by the Executive Account Manager prior to insertion in the manual. When the changes have been approved, the changes are incorporated into the on-line manual. Revised material will be noted as such to the left of the affected section of the documentation, and the effective date of the change will appear directly below. A hardcopy of the revised pages are inserted into the unit manual, and copies of the revised pages are forwarded to all personnel listed on the Manual Distribution List maintained in this section of the manual.

Flowchart Standards

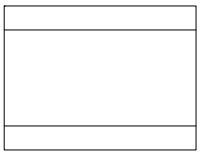
The workflow diagrams included in this document were generated through the flowcharting software product Visio Professional. Descriptions of the basic flowcharting symbols used in the VaMMIS documentation are presented below.

Large Processing Function

Manual Process. No automated processes are used; e.g., clerical function.

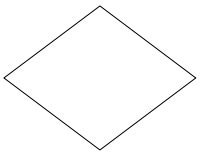


Data Preparation Processing; e.g., mailroom, computer operations, etc.

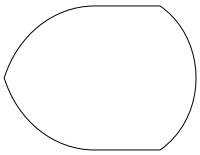


Create a Request

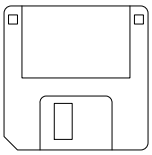
Data maintained in a master datastore.



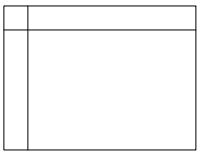
Decision



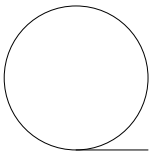
Information entered or displayed on-line.



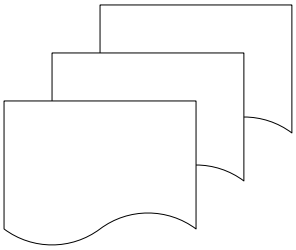
Data stored on diskette media.



On-line Storage; e.g., CD-ROM, microform, imaged data, etc.

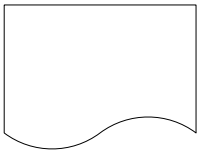


Input or Output Tape



Multiple Outputs; e.g., letters, reports

Communication Link



Single Output; e.g., letter, report, form, etc.

External Entity. Source of entry or exit from a process.

Off-page Connector

1.0 Overview of the Virginia Medical Assistance Program

The Commonwealth of Virginia State Plan under Title XIX of the Social Security Act sets forth the Commonwealth's plan for managing the Virginia Medical Assistance Program (VMAP). It defines and describes the provisions for: administration of Medical Assistance services; covered groups and agencies responsible for eligibility determination; conditions of and requirements for eligibility; the amount, duration, and scope of services; the standards established and methods used for utilization control, the methods and standards for establishing payments, procedures for eligibility appeals; and waivered services.

1.1 Standard Abbreviations for Subsystem Components

For brevity, subsystem components will use these abbreviations as part of their nomenclature.

Abbreviation	Subsystem
AM	Automated Mailing
AS	Assessment (Financial Subsystem)
CP	Claims Processing
DA	Drug Application
EP	EPSDT (Early Periodic Screening, Diagnosis, and Treatment)
FN	Financial Subsystem
MC	Managed Care (Financial Subsystem)
MR	MARs (Management and Reporting)
POS	Point of Sale (Drug Application)
PS	Provider
RF	Reference
RS	Recipient
SU	SURS (Surveillance Utilization and Review)
TP	TPL (Financial Subsystem)

1.2 Covered Services

The Virginia Medical Assistance Program covers all services required by Federal legislation and provides certain optional benefits, as well. Services are offered to Medicaid Categorically Needy and Medically Needy clients. In addition, certain services are provided to eligibles of the State and Local Hospitalization (SLH) program and the Indigent Health Care (IHC) Trust Fund. SLH, Temporary Detention Orders (TDO), and IHC are State and locally funded programs with no Federal matching funds. SLH is a program for persons who are poor, but not eligible for Medicaid in Virginia, which is funded by the Commonwealth and local counties.

Services and supplies that are reimbursable under Medicaid include, but are not limited to:

- Inpatient acute hospital
- Outpatient hospital
- Inpatient mental health
- Nursing facility
- Skilled nursing facility (SNF) for patients under 21 years of age
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Hospice
- Physician
- Pharmacy
- Laboratory and X-ray
- Clinic
- Community mental health
- Dental
- Podiatry
- Nurse practitioner
- Nurse midwife
- Optometry
- Home health
- Durable medical equipment (DME)
- Medical supplies
- Medical transportation
- Ambulatory surgical center.

Many of the services provided by DMAS require a co-payment to be paid by the recipient. This payment differs by type of service being billed, according to the State Plan. Payment made to providers is the net of this amount.

General exclusions from the Medicaid Program benefits include all services, which are experimental in nature, cosmetic procedures, acupuncture, autopsy examination, and missed appointments. In addition, there are benefit limitations for specific service categories that must be enforced during payment request processing.

1.3 Waivers and Special Programs

In addition to the standard Medicaid benefit package, the Commonwealth has several Federal waivers in effect which provide additional services not ordinarily covered by Medicaid, as well as special programs for pregnant women and poor children. The programs include:

- **Elderly and Disabled** is a Home and Community Based Care (HCBC) waiver program covering individuals who meet the nursing facility level-of-care criteria and who are at risk for institutionalization. In order to forestall institutional placement, coverage is provided for:
  - Personal Care (implemented 1982)
  - Adult Day Health Care (implemented 1989)
  - Respite Care (implemented 1989)
- **Technology Assisted Waiver for Ventilator Dependent Children** is a HCBC waiver implemented in 1988 to provide in-home care for persons under 21, who are dependent upon technological support and need substantial ongoing nursing care, and would otherwise require hospitalization. The program has since been expanded to provide services to individuals over age 21.
- **Mental Retardation Waiver** includes two HCBC waivers that were implemented in 1991 for the provision of home and community based care to mentally retarded clients. They include an OBRA waiver for persons coming from a nursing facility who would otherwise be placed in an ICF/MR, and a community waiver for persons coming from an ICF/MR or community. The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) updates the eligibility file for Mental Retardation Waivers.
- **AIDS/HIV Waiver** is a HCBC waiver implemented in 1991 that provides for home and community based care to individuals with AIDS, or who are HIV positive, and at risk for institutionalization.
- **Assisted Living Services** include two levels of payment, regular and intensive. Regular assisted living payments (per day per eligible recipient) are made from state funds. Intensive

assisted living payments (per day per eligible recipient) are covered under an HCBC waiver and are made from a combination of state and federal funds.

- **Adult Care Resident Annual Reassessment and Targeted Case Management** provides for re-authorization and/or follow-up for individuals residing in assisted living facilities. The program includes a short assessment process for individuals who are assessed at the residential level, and a full assessment for individuals who are assessed at the regular or intensive assisted living level. The targeted case management is provided to individuals who need assistance with the coordination of services at a level which exceeds that provided by the facility staff.
- **PACE/Pre-PACE Programs** provide coordination and continuity of preventive health services and other medical care, including acute care, long term care and emergency care under a capitated rate.
- **Consumer-Directed Personal Attendant Services** is a HCBC waiver that serves individuals who are in need of a cost-effective alternative to nursing facility placement and who have the cognitive ability to manage their own care and caregiver.
- **MEDALLION Managed Care Waiver** is a primary care physician case management program. Each recipient is assigned a primary care physician who is responsible for managing all patient care, provides primary care, and makes referrals. The primary care physician receives fees for the services provided plus a monthly case management fee per patient.
- **MEDALLION II Managed Care Waiver** is a fully capitated, mandatory managed care program operating in various regions of the State. Recipients choose among participating HMOs, which provide all medical care, with a few exceptions.
- ***Options*** is an alternative to MEDALLION where services are provided through network providers, and the participating HMOs receive a monthly rate based on estimated Medicaid expenditures.
- **Client Medical Management (CMM)** is the recipient "lock-in" program for recipients who have been identified as over utilizing services or otherwise abusing the Program. These recipients may be restricted to specific physicians and pharmacies. A provider who is not the designated physician or pharmacy can be reimbursed for services only in case of an emergency, written referral from the designated physician, or other services not included with CMM restrictions. The need for continued monitoring is reviewed every eighteen (18) months. The services not applicable to CMM are renal dialysis, routine vision care, Baby Care, waivers, mental health services, and prosthetics.
- **Baby Care Program** provides case management, prenatal group patient education, nutrition counseling services, and homemaker services for pregnant women, and care coordination for high risk pregnant women and infants up to age two.

1.4 Eligibility

Medicaid services are to be provided by eligible providers to eligible recipients. Eligible recipients are those who have applied for and have been determined to meet the income and other requirements for the Department of Medical Assistance Services (DMAS) services under Medicaid. Virginia also allows certain Social Security Income (SSI) recipients to "spend down" their income to Medicaid eligibility levels by making periodic payments to providers.

Virginia is a Section 209(b) state, meaning that the DMAS administers Medicaid eligibility for SSI eligibles and State supplement recipients locally through the Department of Social Services (DSS). DSS administers eligibility determination at its local offices and is responsible for determining Medicaid eligibility of Temporary Assistance to Needy Families with Children (TANF), Low-Income Families with Children (LIFC), and the aged. DSS also determines financial eligibility of blind and disabled applicants. In addition, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) administers recipient eligibility for Mental Retardation Waivers. The Department of Visually Handicapped (DVH) and the Department of Rehabilitative Services (DRS) are responsible for determining the degree of blindness of an applicant and the determination of medical necessity, respectively.

Three categories of individuals are eligible for services under the VMAP: Mandatory Categorically Needy, Optionally Categorically Needy, and Optionally Medically Needy. In addition, DMAS operates two other indigent healthcare financing programs, the State and Local Hospitalization (SLH) and the Indigent Health Care (IHC) Trust Fund.

1.5 Eligible Providers and Reimbursement

Qualified providers enroll with the VMAP by executing a participation agreement with the DMAS prior to billing for any services provided to Medicaid eligibles. Providers must adhere to the conditions of participation outlined in the individual provider agreement. To be reimbursed for services, providers must be approved by the Commonwealth and be carried on the Provider Master File in the MMIS.

DMAS employs a variety of reimbursement methodologies for payment of provider services. Inpatient hospital and long-term care facilities are reimbursed on a per diem prospective rate, which goes into effect up to 180 days after the beginning of the rate period to allow for retroactive payment adjustments. Settlement is based on a blend of the per diem rate and the APG/DRG Grouper reimbursement methodology. Other providers are reimbursed on a fee-for-service (FFS) basis according to a Geographic Fee File maximum amount allowed. In the FFS methodology, payment is the allowed amount, or the charge, whichever is less; payment is adjusted by co-payment, as well as by any third-party payment. Medicare co-insurance and

deductibles received in the crossover system are reduced to the Medicaid allowance when the Medicare payment and the Medicaid co-insurance amount would exceed the Medicaid-allowed amount. In addition to these payment methodologies, the MEDALLION managed care program uses case management fees as well as FSS. MEDALLION II is fully capitated and uses a per member, per month, payment methodology. Health maintenance organizations (HMOs) participating in the *Options* program are paid a monthly rate based on estimated Medicaid expenditures. Monthly fees are also paid for Client Medical Management (CMM).

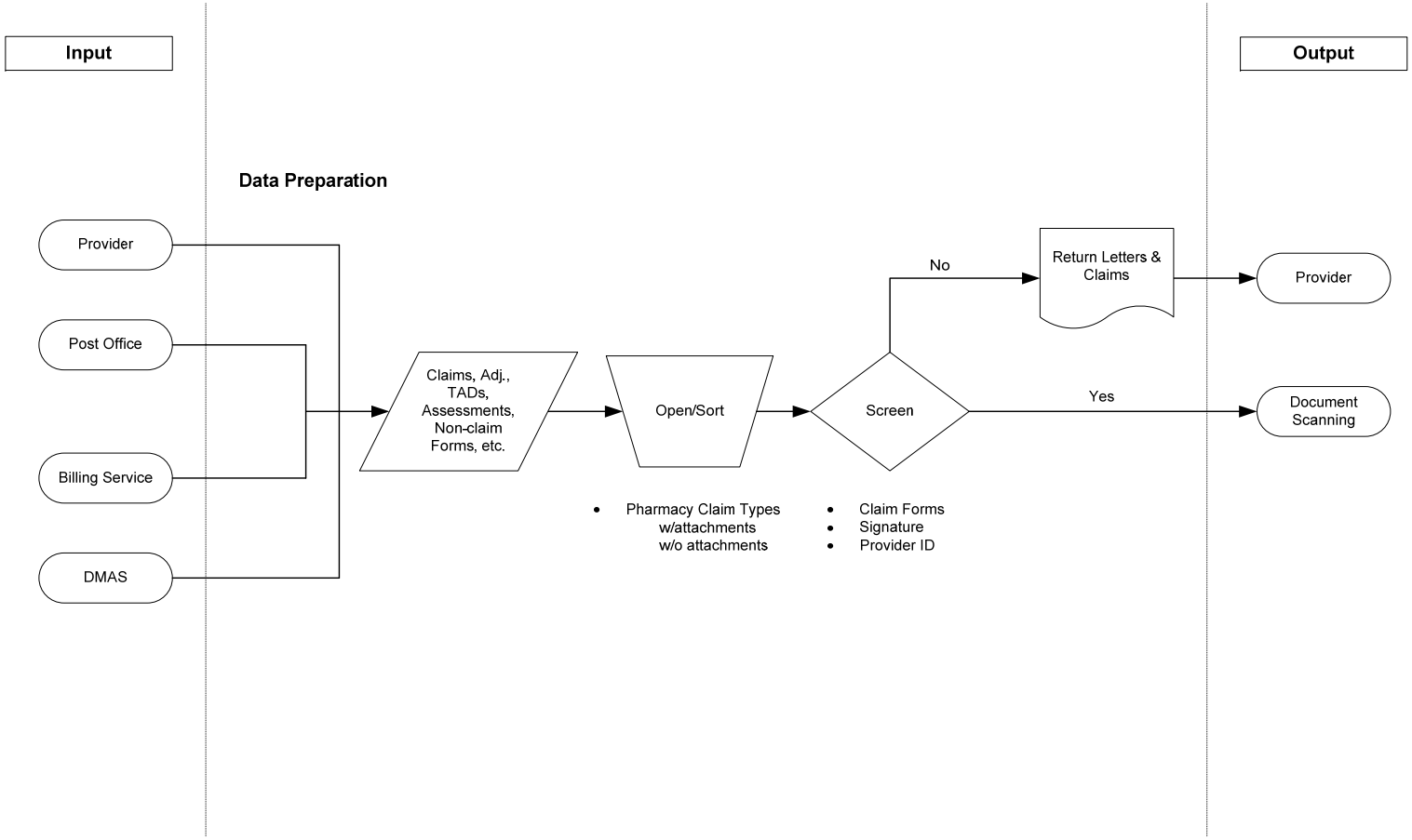
2.0 Receive and Transmit Pharmacy Claims

Each day the courier picks up mail from the Pharmacy Post Office box (27445) and delivers it to the Data Preparation area for processing. The mail is then sorted by PO Box number. Mail addressed to a particular unit or individual, or marked “Personal” or “Confidential” is not opened, but distributed as indicated. All certified mail is logged in the “Certified Mail” notebook.

Additionally, the courier is required to make pickups at state offices. These pickups will be made at agreed-upon times and at designated locations.

WORKFLOW PROCESS

Drug Application Subsystem: Receive and Transmit Pharmacy Claims



2.1 Receive Paper Claims

Input control clerks will receive paper claims for Point of Sale (POS) daily and prepare them for imaging immediately upon receipt.

Procedure

1. Sort all Pharmacy POS payment requests into singles and singles with attachments by invoice type.
2. Check the payment request using these criteria:
   - ❖ No carbon and yellow copies are included
   - ❖ Form is not obsolete
   - ❖ Old ICNs are covered. If ICN is not covered, tape over the old number.
   - ❖ Check to ensure that all payment requests are legible and in black or dark blue ink.
   - ❖ Check to ensure that all payment requests have a provider signature or SOF (Signature on File) indicated.
   - ❖ Check to ensure that billing information such as dates, procedure codes and charges are filled in.
3. For Pharmacy POS claims that meet these criteria:
   - ❖ Remove staples, paper clips, and check for other damage and repair damage. If documents have attachments and/or correspondence, insert patch sheets.

     Do this to insert patch sheets: Insert patch sheets in all payment requests with attachment(s) as follows:

     - – Remove staples or paper clips.
     - – Place the patch sheet with the striped edge at the top in front of the invoice and its attachment.
     - – If there is more than one invoice, place the patch sheet in front of each invoice. (A Patch sheet changes the Image Control Number in the imaging process.)
     - – Process payment requests received with attachments in the order received. Do not change the order of the payment request.
   - ❖ Place payment requests received with correspondence stapled on top of the invoice in the **Miscellaneous** tray marked **State Box**. This refers to letterheads, any size and/or type of “sticky notes”, and notes that have been taped, stapled, or attached in any way on the top of invoices.

- ❖ If there are any pre-printed prescription forms, staple them on top of the pharmacy payment requests.

4. For Pharmacy POS claims that do not meet these criteria:
   - ❖ Tag the document as *Return to Provider* and attach a letter to indicate the reason for return.
   - ❖ Place in the **Return to Provider** tray.

2.2 Enter Paper Claims into System

All paper claims are entered into the system entering the data on the paper claim into a Drug Subsystem screen. The claim may be imaged as part of input control, so you will either bring the image up in the OnDemand browser and key from the image or use the original paper claim. When finished keying, you will check your work against the field edits, then submit the claim into the system.

Procedure

From the VaMMIS Main Menu (RS-S-010):

1. Choose the **Drugs** button.
2. Choose *Benefit Master* from the **Selection** drop-menu.
3. Choose **Enter**.
4. You see the **Benefit Main Menu** (POS-S-012).
5. Select *Add Record* from the **Selection** drop-menu.
6. You see the **Pharmacy Claims Data Entry** screen (POS-S-028).
7. Key information from the form (either paper or OnDemand) into the screen.
8. Choose the **Reset** button to save the data entered on screen.
9. Choose the **Enter** button to submit Processes Screen/Submit Claim for adjudication processing.

2.3 Correct Optically-Scanned Paper Pharmacy Claims

In this process, data not captured in the OCR process is entered onto the system performs. Field zones for which data was not recognized are shown to the operator for manual correction. Field zones for which valid data was not captured are highlighted throughout the image to guide the operator through the keying.

Procedure

For complete procedures, see the Document Scanning and Data Correction Procedures Manual, Section 2.2.3 through 2.2.8.

2.4 Receive Electronic Claims

The PaperFree EC Gateway Server software for NT provides communications, scripting, routing, compliance checking, and translation services for Electronic Data Interchange (EDI). The Gateway Server exchanges data between VMAP and trading partners. Trading partners include pharmacy providers and service bureau providers, and billing agency providers. Trading partners interface with the Gateway via the FTP Server. Data is exchanged between the Gateway and the mainframe application via FTP.

Pharmacy claims are submitted using the NCPDP v 1.0 batch standardized format. Providers have the option of posting their batch transmission to the First Health bulletin board. Providers can use cartridge and or diskette input, but are encouraged to use tapes. First Health monitors the transaction to ensure that claims posted to the Bulletin Board are pulled into the weekly cycle. The system will produce the EDI 835 Health Care Claim Payment/Remittance Advice form as a pharmacy remittance advice

Inbound documents are sent to the Gateway by trading partners using dial-in access to the FIRST HEALTH FTP Server. Each trading partner has a secure user ID and password. This allows providers to send or upload documents like X12 claims, a NCPDP batch, or a PA transmission. The gateway server routes, compliance checks, translates and then transfers the results via FTP to the mainframe VaMMIS application.

Procedure

This is an automated function. No manual procedures are needed.

2.5 Transfer All Processed Claim Data

All processed claim data will be uploaded to the mainframe CICS automatically.

Procedure

This is an automated function. No manual procedures are needed.

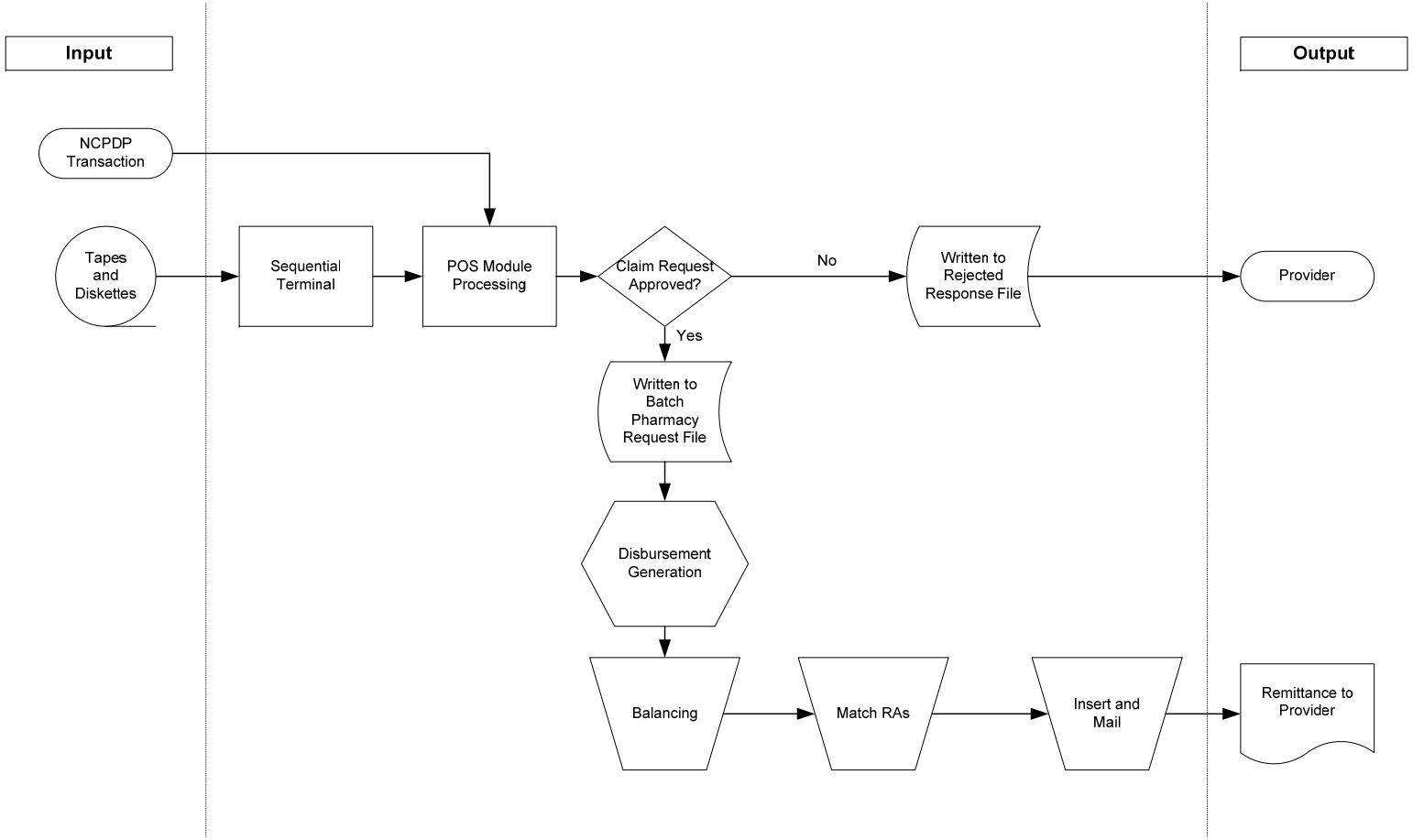
3.0 Process Pharmacy POS Claims

You will use several different processes, both manual and automatic to process Pharmacy POS claims. The VaMMIS accepts direct payment requests from pharmacies and processes the transactions in a real-time mode. A claim that enters the POS system is fully formatted and edited to ensure that all data is can be processed. Data table information such as Benefit Plan, Provider, Enrollee, Medical Codes, etc. are captured based on the values of the corresponding data on the claim.

Once all relevant data is secured, the claims are subjected to various tabledriven payment and restriction rules. These rules and edits are defined in the various programs that comprise the POS system. The resulting affect of each edit is controlled through the Error Text File, which will be maintained differently for each benefit group. Once all applicable edits have been performed for a payment request, the status of the request is determined and the request is routed appropriately. A resulting paid or denied payment request is written to history during the adjudication process in preparation for the next related payment request submission. The payment requests are also accumulated for weekly remittance advice and disbursement generation processing within the same week the claims are adjudicated.

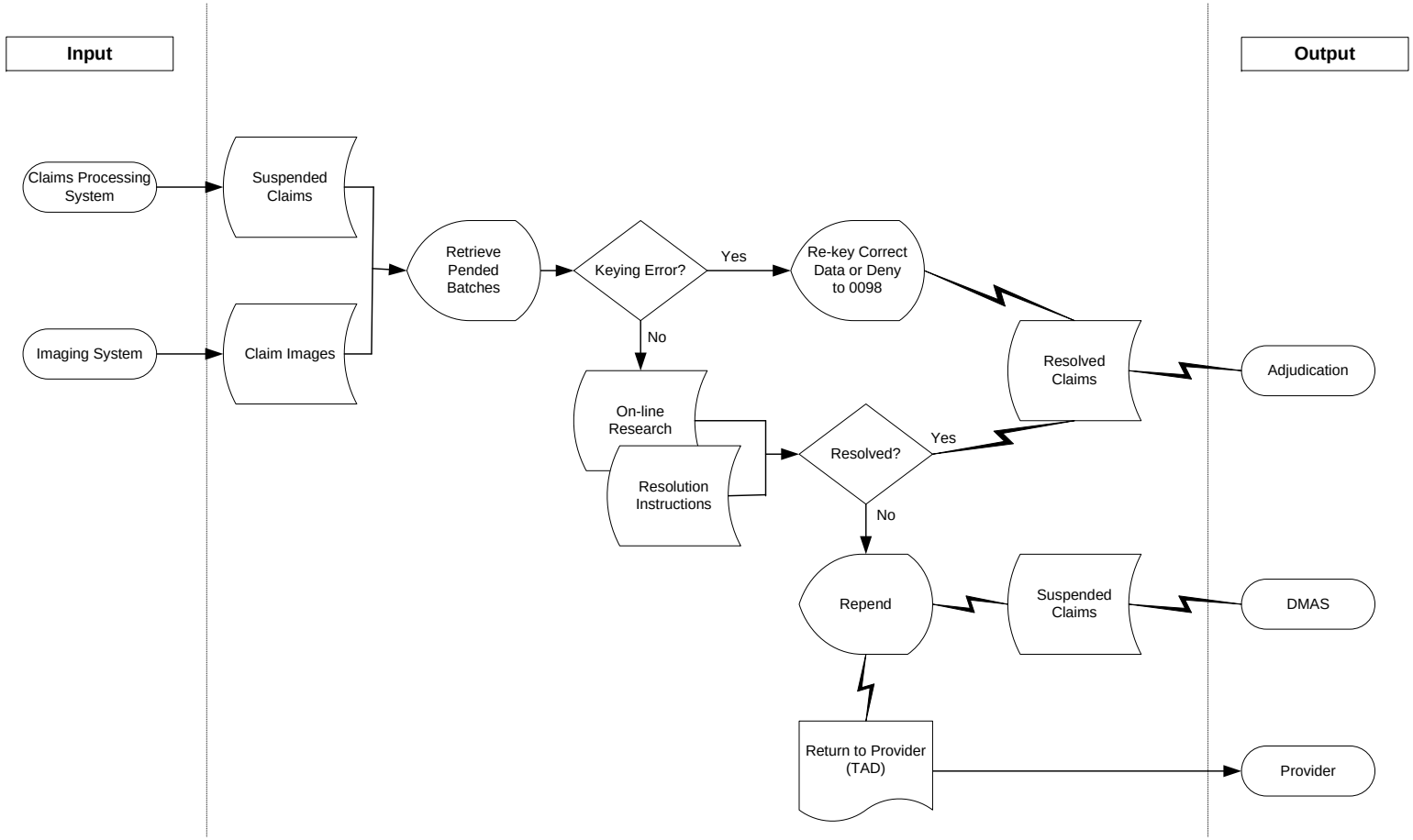
WORKFLOW PROCESS

Drug Application Subsystem: Process Electronic Claims



WORKFLOW PROCESS

Drug Application Subsystem: Resolve Pended POS Claims



3.1 Pay Pharmacy POS Claims

Pharmacy POS claims that are approved after POS processing are written to a batch pharmacy file for disbursement generation via NCPDP. Remittance Advices are mailed to Providers after balancing of the POS program.

Procedure

1. Separate a group of RAs into ZIP code groups.
2. Insert the RAs into envelopes for mailing.
3. Take the envelopes to the mail room for mailing.

3.2 Resolve Pended Pharmacy Claims

In this task, you will resolve a pended (POS) Point of Sale claim using a series of screens devoted to the task. You will choose a specific claim to pend or choose to work on all the pended claims, starting from the oldest one on file. When you have resolved the pend, you will submit the claim to the on-line batch adjudication program.

Resolving Pended POS Pharmacy claims involves researching paper claims for the reasons the claim was initailly pended, finding a resolution to the problem, and changing the status of the claim. You will also research claims received in NCPDP format and resolve their pend status. You'll research the electronic claims by NCPDP version number.

During mainframe processing, validity edits and history audits cause payment requests with errors to be suspended for review by First Health and/or DMAS staff. Pended claims are automatically routed by the system to pend locations at both First Health and DMAS. Locations are listed below. Note that some locations are transfer locations only, meaning that claims are not automatically assigned to them.

As each pended claim is presented, the corresponding claim image stored on the mainframe is also retrieved providing staff with a paperless image of the original claim for comparison with the on-line claim record. If the claim or a conflicting claim predates the imaging process, the operator will obtain a microfilm copy of the claim or conflicting claim for review. Resolution staff should work all location pends for which they are authorized. After resolution, the claim is re-entered into the system. If more errors are encountered, the system will pend the claim again and route it to the next appropriate location. Each subsequent pend condition is resolved and re-entered until the claim is either paid or denied. The graphic on the following page represents the overall Workflow Process of the Pend Resolution Unit.

Pended claims are reviewed and resolved according to policy and guidelines approved by DMAS. Each edit is first researched in the on-line Edit/Audit Manual, which contains the edit

description and instructions for resolution. Resolution is implemented via the appropriate on-line screen.

Pend Resolution staff retrieve claims/claim images individually on-line. Electronic claim images are automatically retrieved for each pended claim presented on the relevant Pend Resolution screen. The IBM OnDemand Document Archive and Retrieval System (DARS) is the system that produces and archives electronic copies of all VaMMIS imaged documents. Once resolution is determined, the claim may be corrected, overridden, denied, repended to the Resolution Supervisor for further review, or to DMAS for medical review.

If keying errors are found In the course of resolving a pend, the operator corrects the error if the error is in an unprotected field. If the error cannot be corrected, the payment request is denied using error code 0098 and the payment request must be reimaged and rekeyed in data entry.

While pends are presented for resolution in date order, it is possible that a pend may not be resolved timely resulting in aged pends. These pends are listed on aged pend reports (30, 60, 90, or 180 days) which are used by resolution staff to retrieve and resolve specific claim records. Such claims can be retrieved individually by either provider ID, claim type, or ICN.

Procedures

Retrieve Pharmacy Claims

1. Choose the **Drug** button from the **Virginia Medicaid Main System Menu**.
2. You see the **Help Desk Main Menu** (POS-S-000).
3. Choose *Claims* from the **Selection** drop-menu. Choose the **Enter** button.
4. You see the **Online Pend Resolution Menu**.
5. Enter your authorized pend location in the location field and choose **Enter**.
6. You see the oldest pended claim for the location in the **Online Pend Resolution Pharmacy** screen (POS-S-030) along with the corresponding claim image.

For more details on specific screen navigation and field entries, or specific data elements, refer to the on-line Claims Processing Subsystem User Manual and/or the On-Line HELP System.

Check for Keying Errors on Pharmacy Claims

1. Begin with the first error code displayed in the **Errors** field that you are authorized to resolve.
2. If a keying error in a protected field caused the error, deny the claim by entering Error Code *0098* in the first 4-character field of the **Resolution Ind** field directly below the error.

3. Enter a *D* in the 1-character field directly beside the **Resolution Ind.** Field Refer to Section 6.1.4 - Resolve Keying Errors, in the Claims Resolution procedure manual for further instructions on keying errors.
4. If there are no keying errors, begin to resolve the claim using the Edit/Audit manual and the procedures that follow.

Resolve the Edit/Audit Using the Edit/Audit Manual

As you enter corrected data into the appropriate fields, choose Enter to edit the data you have entered. You may edit each changed field individually, or wait until all fields have been entered and choose Enter to edit at one time. Fields in error will be highlighted for re-entry.

Use the on-line Edit/Audit lookup or the Edit/Audit manual for pend resolution procedures in this section.

1. Look at the Errors listed in red text next to the **Errors:** field.
2. Find the error (ESC number) in the on-line Edit/Audit manual on Edit/Audit online lookup.
3. Follow the instructions for each different resolution:

Edit/Audit Instruction	Do this…
Deny	1. Enter the 4-character **ECS** number (the number displayed in the **Errors** field) in the **Resolution Ind** field. 2. Enter a *D* in the **Disposition Indicator** field, the 1-character field to the right of the **Resolution Ind** field. 3. Choose the **Enter** button.
Override	1. Enter the 4-character **ECS** number (the number displayed in the **Errors** field) in the **Resolution Ind** field. 2. Enter an *O* in the **Disposition Indicator** field, the 1-character field to the right of the **Resolution Ind** field. 3. Choose the **Enter** button.
Repend	1. Enter a 3-character new location code in the **Loc To:** field to the right of the **Loc From** field. 2. Choose the **Enter** button.
Pay	1. Enter the 4-character **ECS** number (the number displayed in the **Errors** field) in the **Resolution Ind** field. 2. Enter a *P* in the **Disposition Indicator** field, the 1-character field to the right of the **Resolution Ind** field. 3. Choose the **Enter** button.

For more details on specific screen navigation and field entries, or specific data elements, use the On-Line HELP system or the Drug Application User Manual. For resolution instructions for each error code, refer to the Edit/Audit Manual or Edit/Audit Lookup page, which can be accessed through the On-Line HELP system.

3.3 Research Rejected POS Claims

In this task, you will screen and research rejected electronic claims submitted to the POS Advanced Pharmacy Processor (APP). All of these claims are submitted in NCPDP format and automatically submitted to the VaMMIS. The claims you see have already been reviewed by the APP and rejected.

Procedure

From the VaMMIS Main Menu (RS-S-010):

1. Choose the **Drugs** button.
2. You see the **PRN Main Menu** (POS-S-000).
3. Choose *Online Current Rejects* from the **Selection** drop-menu.
4. Choose **Enter**.
5. You see the **On-line Reject Record Menu** screen (POS-S-023).
6. Enter a Code in the **Version** field. (See the Online HELP system for valid NCPDP codes).
7. Enter a Provider or Enrollee ID in the **Provider** or **Enrollee** field. To narrow your search, enter an Rx number or From Date in the fields in the **Optional** box.
8. Choose **Enter**.
9. You see the You see the **On-line Reject Records** screen (POS-S-024). All of the rejected records for the criteria entered are listed on this screen.
10. Select (highlight) a record you want to research/change data for. Choose the record according to the type of NCPDP transaction code.

NCPDP Code	Cause for Pend	Details on Screen
00	Eligibility of recipient.	Eligibility Detail screen (POS-S-026).
11	The POS transaction was voided.	Reversal Detail screen (POS-S-027).

11. From either screen (**Eligibility Detail** or **Reversal Detail**) choose the **Enter** button.

12. You see the **On-line Reject Records** screen (POS-S-024).

3.4 Report Pharmacy POS Claims

Pharmacy POS claims information are reported on a weekly report Weekly POS Transaction Totals For MM/DD/YY (POS-O-001). This report is produced by the VaMMIS automatically and routed to the OnDemand report repository for viewing by the end user.

Procedure

No user input required.

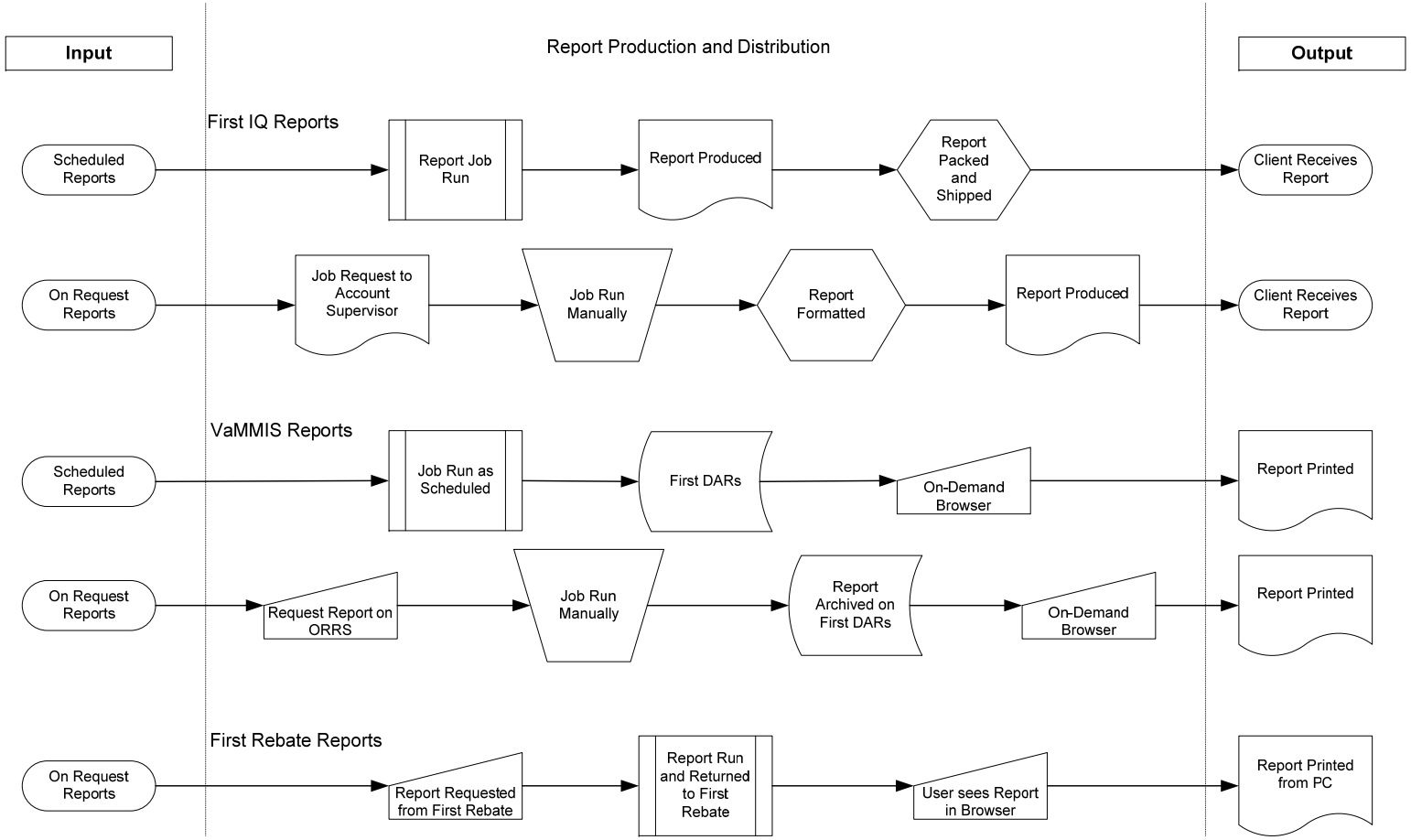
4.0 Produce and Distribute Reports

The Virginia MMIS and associated Pharmacy systems will produce reports on a universe of stored data. Reports that are produced from the VaMMIS, POS and ProDUR reports, will be distributed via the First DARs On-demand product. These reports will be available to end users via their PC's web browsers. First Rebate reports will be available to users via a web browser.

First IQ scheduled reports will be produced and printed at First Health, then sent to clients. Ad hoc reports and on-request special reports are also produced at First Health and sent to clients. These special reports are prepared only in response to a request made to the account manager.

WORKFLOW PROCESS

Drug Application Subsystem: Produce and Distribute Reports



4.1 Produce and Distribute FirstIQ Reports

Most First IQ reports are scheduled to run weekly, monthly, quarterly, etc. Scheduled reports are packaged and shipped by the First IQ support group. Clients can request an ad hoc report (known as a PURF request) from the account supervisor, who schedules the job with the First IQ report group.

This group also produces the report and processes it for delivery to the client.

Procedures

Scheduled Reports

No manual scheduling or report modifications. Completed reports will be boxed and/or bound and mailed to clients.

PURF Reports

1. Client completes a PURF report request.
2. Client sends the request to the account manager.
3. The First IQ Report group sets up the report job and manually runs the report.
4. The Report Group produces the report, packages it and sends it to the client.

4.2 Produce and Distribute Pharmacy Claims Processing Reports

Pharmacy claims reports are produced and run on a schedule. As such, all of these reports are available for viewing and printing from a user's PC via the First DARS On-Demand web client. The report can be printed from the client's PC. These reports are produced from the Point of Sale (POS) and Pro-DUR programs in the VaMMIS.

- Paid Claim Processing Exception
- Non-Paid Claim Processing Exception
- (Exception) Message Report
- Prospective DUR Message Report (with Provider Counts)
- Prospective DUR Message Report (with Recipient Counts)
- Prospective DUR Message Report (with All Error Counts)
- Weekly POS Transaction Totals For Week Ending MM/DD/YY

Procedure

There are no manual procedures associated with this task.

4.3 Produce and Distribute Pharmacy Rebate Reports

Pharmacy Rebate reports are the exclusive preserve of the First Rebate Web Reports program. This program has extensive reporting capability, including reports in four broad categories:

- Management Reports
- Dispute Resolution Reports
- Invoice Cycle Reports and
- Receipts Reports

Reports are requested via a web browser and viewed at the client's PC. The reports can be formatted in a choice of output formats, including Word documents, RTF files, Excel spread sheets, or Crystal Reports.

Procedure

There are no manual procedures associated with this task. See the First Rebate User Manual and First Rebate Web Reports user manuals for complete instructions.

4.4 Evaluate FirstIQ Reports

Monthly, the Clinical Manager views on-line the report of **Class and Problem Counts**. This report details the number of exceptions by class for each problem type for which criteria exists. The problem types include Overutilization, Underutilization, Treatment Failure, Drug to Diagnosis, Drug to Drug, Iatrogenic and Adverse Reaction. The client has determined a schedule for RetroDur review of various therapeutic classes. A Criteria Report is also available for viewing or printing which details all therapeutic drug criteria on the VA Criteria file.

Monthly, when this process is completed, a report of the review, lettering process, and response tracking is prepared by the Clinical Manager for the Virginia DUR Coordinator. A copy is sent to Finance to be included with the invoice to the client for these RetroDur services.

Procedures

Recipient Profiling

Monthly, the Clinical Manager views on-line the report of "Class and Problem Counts". This report details the number of exceptions by class for each problem type for which criteria exists. The problem types include Overutilization, Underutilization, Treatment Failure, Drug to

Diagnosis, Drug to Drug, Iatrogenic and Adverse Reaction. The client has determined a schedule for RetroDur review of various therapeutic classes. A Criteria Report is also available for viewing or printing which details all therapeutic drug criteria on the VA Criteria file.

1. The Clinical Manager must determine how many profiles (**Patient Intervention History** reports) to print of each problem type within the determined therapeutic class so that 1000 profiles can be distributed to reviewers for meaningful clinical review. The profiles are selected (by Clinical Manager) and printed (by Reporting Analyst) and distributed--100 profiles to each of 10 reviewers (by Reporting Analyst).
2. The Clinical Manager prepares a monthly instruction letter and gives it to Reporting Analyst to add to each packet of profiles before they are put into envelopes for mailing. The profiles, ready for mailing, are taken to mailroom by Reporting Analyst. The profiles must be mailed within five days of being printed. A Profile Summary Report and Re-Review Profile Summary Report (re-review profiles are produced along with monthly profiles six months after a letter is sent on a profile as a method of review of changes in therapy resulting from letters sent) are records of the profiles selected and printed for distribution.
3. A set of reports produced with the profiles are analyzed by the Clinical Manager for significant areas of clinical concern and suggestions for future clinical review. These reports include the Baseline Exception Summary, Totals Information, Exceptions Reviewed by problem Type, Exceptions Reviewed by Class, Exceptions Reviewed by Region, Standard Class on New Maintenance Savings Report and Intervention Savings report.
4. The reviewers (physicians and/or pharmacists selected and hired as consultants by First Health) must review the profiles for clinically significant exceptions to the therapeutic drug criteria indicated on each profile. The reviewers have four weeks to return the profiles to the Clinical Manager.
5. The Clinical Manager reviews the returned profiles for quality and consistency of review and to determine any clinical issues concerning criteria that should be brought before the VA DUR Board for discussion. The Clinical Manager clearly identifies the criteria on each profile that needs to be lettered and who (physician and/or pharmacist) should receive the letters. Any profiles not requiring a letter may be discarded.
6. The profiles which need to be lettered should be submmitted to the Reportin Group in a timely fashion for production of letters and response sheets. This should be accomplished so as provide at least a week for lettering and review by the Clinical Manager before submission by the Reporting Group to Operations.

7. Three reports for review and reference by the Clinical Manager are produced with the letters. A Turnaround Document details the letters sent, a RetroDur Utilization Review Profile Intervention details interventions and a Provider Letter Summary details where the letters were sent.
8. Operations will collate the letters with a copy of the profile being lettered and a DUR Program Information sheet. This packet of information will be put into envelopes for mailing to providers. The mailing must be accomplished within six weeks of the date the profiles were originally mailed to reviewers.
9. As response sheets are returned, the Clinical Manager reviews them and submits them to the Reporting Group for tracking.
10. Monthly, when this process is completed, a report of the review, lettering process and response tracking is prepared by the Clinical Manager for the VA DUR Coordinator. A copy is sent to Finance to be included with the invoice to the client for these RetroDur services.

Provider Profiling

Bi-monthly, DMAS claims data will be organized into provider histories. The provider histories will be subjected to the appropriate professional review criteria as requested by VA DMAS and printed as Provider Profile Reports. The profiles shall be produced applying weighing and ranking mechanisms, which have been approved prior to use by the DMAS DUR Board, to sort exceptions by potential seriousness.

The exception profiles will be reviewed to determine which profiles require provider notification.

11. Standard reports will be generated at the end of every profile run. Sorting options are available for each data page of these reports. Quality assurance and audit reports are included to ensure that profiles are generated correctly and should be directed to the Clinical Manager for review. The standard reports include Pharmacy Exception Report, Prescriber Exception Report, Pharmacy Ranking Report, Prescriber Ranking Report, Pharmacy Letter Summary Report, Prescriber Letter Summary Report, Overall Letter Summary Report, Summary of Lettered Exceptions and Response Summary Report. These reports will be reviewed by the Clinical Manager for analysis of clinical issues of concern and recommendations for future therapeutic criteria review.
12. Optional Standard Reports may be requested by VA DMAS as well as Customized Reports. Template reports can be used to include Top 20 Drugs by Prescriber, Top 20 Drugs by Pharmacy, Top X Criteria Exceptions, Pharmacy Ranking Report, Prescriber Ranking Report, Recipient Letter Detail Report, Pharmacy Formulary Usage Report,

Prescriber Formulary Usage Report, Default Provider ID Report, Pharmacy Utilization Report and Prescriber Utilization Report. These reports can be reviewed by the Clinical Manager for prescriber and pharmacy utilization and trends to give direction for future therapeutic criteria review.

13. Intervention letters are generated and forwarded to providers. Educational materials may be included if determined necessary by the DUR Board.
14. Follow-up profiles will be generated during the sixth month following the initial intervention.
15. Follow-up intervention letters will be generated and forwarded to providers as deemed necessary.

4.5 Evaluate Pharmacy Claims Processing Reports

There is a series of reports produced from the Claims processing system that report on aspects of the Pharmacy claim processing process. Some reports containing Pharmacy Claims Processing data are listed below. The Quality Control group will do on-going evaluation of the claims processing for each group. For a complete description of the reports and the associated data elements, see the On-line HELP system or the Claims Subsystem or Drug Application Subsystem User Manuals.

Report Name	Contents as related to Pharmacy Claims
Daily Input Summary (CP-O-001-03)	Lists total records in and billed charges by claim type. It reports the results of input of the daily claims to the first program in the daily cycle.
Paid Claim Processing Exception (PD-O-001)	This report identifies, by pharmacy provider, the number of paid claims that received ProDUR messages, the number of these claims that were reversed by the dispensing pharmacist and the associated cost savings. A summary page for all providers is also produced.
Non-Paid Claim Processing Exception (PD-O-002)	This report identifies, by pharmacy provider, the number of denied claims that received ProDUR messages, the number of those claims that were resubmitted by the dispensing pharmacist and the associated cost savings. A summary page for all providers is also produced.
Enrollee Medical Services Report (CP-O-008-02)	This report lists requested claim detail for a selected enrollee. The request for the profile is entered via on-line or batch transactions to the Claims History Information Retrieval Processor, CHIRP system.
Weekly Pended Claims (CP-O-056-1T)	This report prints a list of all pended claims after the weekly processing, by invoice type within unit. This report counts all pends on the table, not just the newly pended claims from the weekly

Report Name	Contents as related to Pharmacy Claims
	process.
Deny Analysis Report (CP-O-090-01)	This report is a matrix by error code and claim type of claims denied in the daily adjudication cycle. Columns are totaled by error code for each claim type.

5.0 Maintain Professional Review Criteria

Therapeutic Review Criteria on approved drugs is evaluated regularly by therapeutic class category. Any new drugs which are approved by the FDA are evaluated as they become approved. Each drug is evaluated for early and late refill limitations determining overutilization and underutilization, appropriate use of generic products, therapeutic duplications, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions and clinical abuse/misuse.

Therapeutic Review Criteria must be evaluated by the members of the VA DUR board at quarterly meetings. Following the approval of the Review Criteria, the information is entered into the criteria files.

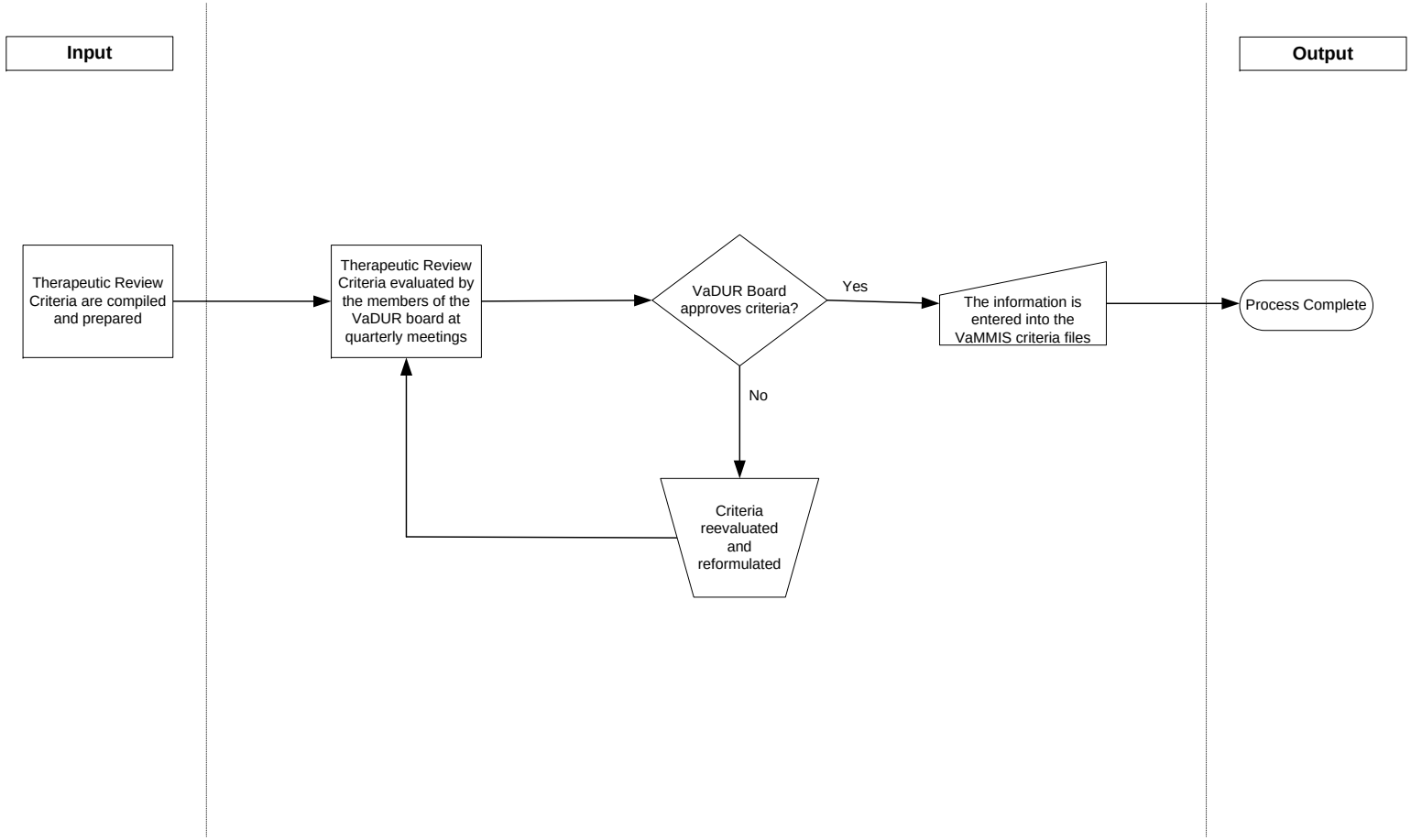
The Drug Utilization Review (DUR) function provides for a prospective review of drug prescribing and dispensing by providers and drug use by beneficiaries. From this data, the Drug Utilization Review Board recommends criteria and standards to DMAS for use in pro-DUR. Criteria for prospective and retrospective drug utilization must be consistent with each other. Criteria and standards must also conform to the other requirements and policies as implemented by DMAS. At a minimum, the Fiscal Agent must provide clinical information for prospective DUR processing to individual pharmacies utilizing criteria recommended by the DUR Board, as approved by SRS. An automated, integrated prospective DUR system that incorporates use of the MMIS BEVS and ECC capabilities, including direct access to the MMIS and point-of-service capability shall be provided to pharmacy providers.

The prospective component of the DUR system alerts Medical Assistance Pharmacy Providers to potential problems with the prescription for the beneficiary via accessing the client's drug profile (created from previous ProDUR transactions) and processing them against a drug database. ProDUR can prevent the dispensing of inappropriate prescriptions through direct intervention by the pharmacist. The objectives of prospective DUR:

- Promote efficiency and cost effectiveness in the use of pharmaceutical services.
- Prevent & reduce inappropriate use of drugs and help identify possible inappropriate drug therapy patterns.
- Develop therapeutic class criteria to reduce the incidences of drug therapy failure, drug-induced illness and any other drug related contraindications.
- Establish and maintain drug history profiles.

WORKFLOW PROCESS

Drug Application Subsystem: Maintain Professional Review Criteria



5.1 Evaluate Therapeutic Review Criteria

Therapeutic Review Criteria on approved drugs is evaluated regularly by therapeutic class category. Any new drugs which are approved by the FDA are evaluated as they become approved. Each drug is evaluated for early and late refill limitations determining overutilization and underutilization, appropriate use of generic products, therapeutic duplications, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions and clinical abuse/misuse.

Procedure

1. The clinical Manager determines any new drugs approved by the FDA for which all criteria must be written. The Clinical Manager determines both the RetroDUR and ProDUR criteria that exist for each drug within the therapeutic class(es) under review and suggests additions and/or deletions.
2. Compendia consisting of DrugDex, USPDI and AHFS as well as peer-reviewed medical literature are used in this process. All severity level 1 and 2 interactions are included in ProDUR and all severity levels 1, 2, and 3 interactions are included in RetroDUR.
    - ❖ Severity Level 1 includes contraindications.
    - ❖ Severity Level 2 includes combinations that “should be avoided” or are “not recommended.”
    - ❖ Severity Level 3 includes combinations requiring monitoring of laboratory values, clinical impact or morbidity/mortality.

5.2 Revise Therapeutic Review Criteria

Therapeutic Review Criteria must be evaluated by the members of the VA DUR board at quarterly meetings. Following the approval of the Review Criteria, the information is entered into the criteria files.

Procedure

1. After Therapeutic Review Criteria have been evaluated by the Clinical Manager, drug criteria grids are made up.
2. The drug criteria grids are presented for review to the members of the Virginia DUR board at a quarterly meeting.
3. Board members may add/delete or modify information as needed.
4. The final information is voted on and approved or amended by the board.

5. Approved information is entered into the account's criteria files by the Virginia Pharmacist.

5.3 Update Therapeutic Review File

The Therapeutic Review File is updated as directed by the Va DUR board. The RetroDUR criteria is kept and updated in the First IQ database by the Clinical manager. The ProDUR criteria is kept and updated on the VaMMIS by the Clinical Manager.

Procedure

The user manuals for the First IQ and VaMMIS Drug Application Subsystem contain complete instructions for updating the Therapeutic Review File(s). These VaMMIS screens are used to update the ProDUR file:

- Drug to Drug Interaction
- Excessive Quantity
- Excessive Daily Dose
- Excessive Daily Dose Over Age
- Excessive Daily Dose Under Age
- Insufficient Daily Dose
- Insufficient Daily Dose Over Age
- Insufficient Daily Dose Under Age
- Underutilization
- Drug to Chronic Interaction
- Inferred Pregnancy
- Therapeutic Duplication
- Age Conflict
- Drug to Allergy Interaction

6.0 Process Drug Rebate Invoices

In order for states to receive Federal Medicaid funds for covered drugs of a labeler [entity which holds legal title to the National Drug Code (NDC) number of the drug product], that labeler must enter into a rebate agreement with the Federal government. The rebate agreement provides that a labeler will rebate to the states a portion of the price the labeler received from the sale of the labeler's covered drugs which were paid for by the state's Medicaid agencies. Without an agreement in force, states would not receive federal funding for recipient outpatient prescriptions for covered drugs of any non-participating labeler.

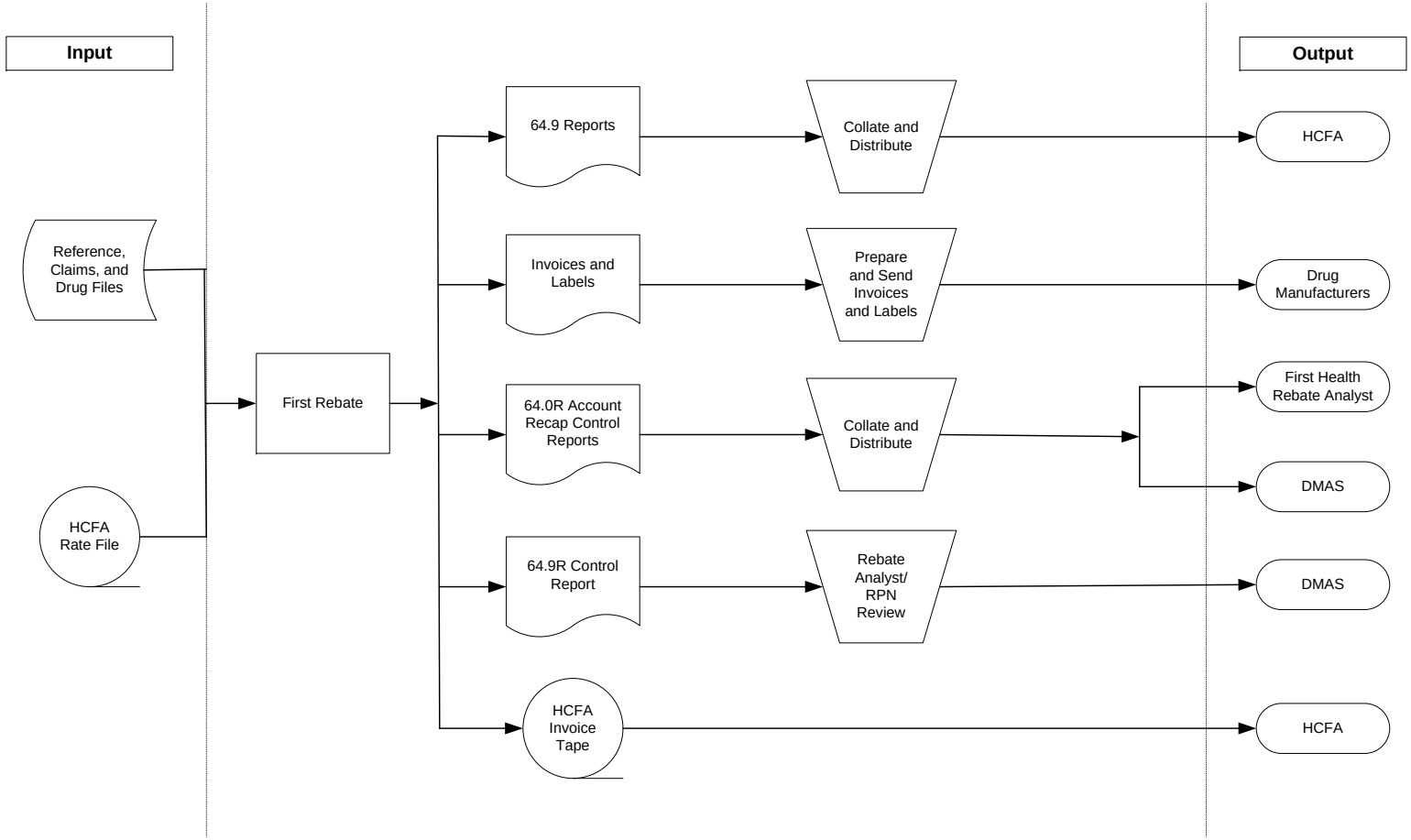
Under the Rebate Program certain information is provided on a calendar quarter basis. Within 30 days after the conclusion of the quarter, labelers submit to CMS pricing information for the covered products of the labeler. The pricing information is utilized to calculate the rebate per unit (or synonymously, unit rebate amount) for each covered product. Within 45 days after the end of the quarter, CMS transmits this information to all states participating in the Rebate Program via electronic media. The states then merge utilization data, for the covered drugs, with the rebate per unit data to produce drug rebate invoices. The invoices are submitted to the respective labelers within 60 days after the close of the quarter. Correspondingly, the states report the utilization data to CMS within 90 days after the end of the quarter. Labelers have 38 days after the mailing of the states' invoices, to remit timely payment. Labelers may remit the entire invoiced amount or dispute a portion thereof and remit partial payment. Labelers may only dispute the number of units invoiced. Partial payments and non-payments are subject to interest, the accrual of which and rate thereof being established by CMS (Center for Medicare and Medicaid Services—formerly HCFA) guidelines.

Dispute resolution is conducted between the respective labeler and state, with minimal involvement by CMS.

First Health's Rebate Operations Department manages the drug Rebate Program in Virginia. The extent of First Health's responsibilities are limited to generating and forwarding rebate invoices, conducting dispute resolution and updates and maintaining a labeler accounts receivable file.

WORKFLOW PROCESS

Drug Application Subsystem: Process Drug Rebate Invoices



6.1 Maintain Internal Policy

First Health maintains its internal policy according to state and federal regulations and CMS (formerly HCFA) guidelines. Any decisions for change in policy or procedures must be agreed to by the client and the Directors of the Account and Clinical Management and the Pharmacy Systems divisions.

Procedure

No manual procedures are used.

6.2 Issue Drug Rebate Invoices

Within 30 days of the end of a quarter, labelers submit to the Center for Medicare and Medicaid Services (CMS) pricing information for the covered products of the labeler. The pricing information is utilized to calculate the rebate per unit (or synonymously, unit rebate amount) for each covered product. Within 45 days after the end of the quarter, CMS transmits this information to all states participating in the Rebate Program via electronic media. The states then merge utilization data for the covered drugs with the rebate per unit data. First Health takes this data and produces drug rebate invoices. The invoices are submitted to the respective labelers within 60 days after the close of the quarter. Labelers have 38 days after the mailing of the states' invoices, to remit timely payment. Labelers may remit the entire invoiced amount or dispute a portion thereof and remit partial payment.

Procedure

1. The Rebate Operations Manager receives the CMS tape.
2. The Rebate System Staff contacts the Rebate Pharmacist and Rebate Analyst to determine if invoices are ready to be run. (First Health Rebate Department may need to enter payments or PHS providers, CPT codes or T-bill rates.)

The Rebate Pharmacist Analyst does this:

1. Completes Virginia Rebate Pre-Invoice checks (rate adjustments, unit adjustments, Pharmacy Claims reversals for particular NDCs if needed).
2. Runs the quarterly invoices, prior period adjustments, cover letter and mails these items to the respective labelers.

First Health Rebate Analyst/Pharmacist are required to do this every three months (quarterly):

3. Runs the 64-9R Quarterly Invoice total report
4. Prints and sends a copy of the invoices to the labelers.

Note: Copies of this report are automatically ported to the web server.

5. Makes a diskette from the downloaded text file for each manufacturer with an invoice greater than the threshold of $50. The report sorts labelers by the labeler number.
6. Places the label on the diskette.
7. Places label on the envelope.
8. Inserts cover letter.
9. Stuffs envelopes for each labeler with their paper invoice package and their diskette with their bills.
10. Brings all invoices at one time to the Mailroom for each state.
11. Mails invoices to labelers with the same postmark. The invoices have to have the same postmark as interest is accumulated from the post mark date.

    Note: Remember that interest will be charged if more than 38 days have passed since the postmark date on the First Health quarterly invoice package. Interest will accrue on all outstanding amounts that have not been identified as specific NDC disputes.

6.3 Perform Threshold Accounting

The First Rebate Program establishes and maintains threshold accounting. Currently, the threshold limit is set at $50 and $250, with $50 being the least amount for which an invoice will be created. These thresholds can only be changed on official request of the state. Threshold limits are set and maintained in the First Rebate program. See the First Rebate Users Guide (Appendix A) for detailed instructions.

Procedure

6.4 Resolve Disputes

When a labeler disputes the payment of a rebate invoice, either partially or in its entirety, the dispute resolution procedure is governed by guidelines set forth by CMS. Presently, First Health utilizes a web-based database to catalog and track disputes. The system is utilized to produce provider level drug claim reports which are essential in resolving disputes. These reports provide details of the individual drug claims which make up the utilization total. These claim detail reports are de-identified, prior to being sent to manufacturers. The report has all the NDCs by labeler. The NDCs that are disputed have data in dispute codes. Adjustment codes are used for resolution.

Procedure

1. The FHSC Rebate Analyst interprets the rebate code on the ROSI using the following definitions:

   Dispute Codes (Maximum of 3 Codes Permitted per NDC)

   - N = Discontinued/Terminated NDC for which the shelf life expired more than one year ago.

- O = Invalid/miscoded NDC.
- P = State units invoiced exceeded “expected” unit sales. Attach supporting methodology and data source).
- Q = Utilization/quantity is inconsistent with the number of prescriptions.
- R = Utilization/quantity is inconsistent with pharmacy reimbursement levels.
- S = Utilization/quantity is inconsistent with state historical trends.
- T = Utilization/quantity is inconsistent with lowest dispensable package size.
- U = Product not rebate eligible (Give details).
- V = No record of sales in state (Attach data source).
- W = Closed out. All disputes settled.

2. The Manufacturer Rebate Analyst assigns the Dispute Code and the transaction, assigning the following Adjustment Codes to the proper field on the ROSI report.

   Adjustment Codes

   - A = Rebate amount per unit has been revised by labeler and reported CMS.
   - B = Labeler has calculated rebate where none reported by state CMS.
   - C = Units invoiced adjusted through mutual agreement between labeler/state.
   - D = Labeler/state unit discrepancy (e.g. GM vs. ML).
   - E = Labeler/state decimal discrepancy.
   - F = Converted NDC (e.g. correction to package size).
   - G = Transferred NDC to another labeler code (documentation required).
   - H = Utilization change from the state.
   - I = Rebate per unit amount adjusted though correspondence between labeler/state. Use this code only when the state has reported a rebate per unit that does not reflect an amount based on pricing data reported by the labeler and adjustment code A is not applicable.

3. The manufacturer rebate analyst attaches any necessary documentation to the package and prepares it for return mailing to the state with the payment.

6.5 Process Adjustments

The Rebate Analyst will process dispute resolution adjustments and adjustments taken by labelers without state approval. All adjustment processing is done on the First Rebate screen for the adjustment segment of the program. The Commonwealth of Virginia forwards Medicaid Drug Rebate Reconciliation of State Invoices (ROSI) to First Health Services. This report has all the NDCs by labeler. The disputed NDCs have data in dispute codes. Adjustment codes can

be made to the units and the rates. For step-by-step procedures on processing adjustments, see the First Rebate End User's Manual in Appendix A.

Procedure

[redacted]

2. [redacted]

[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

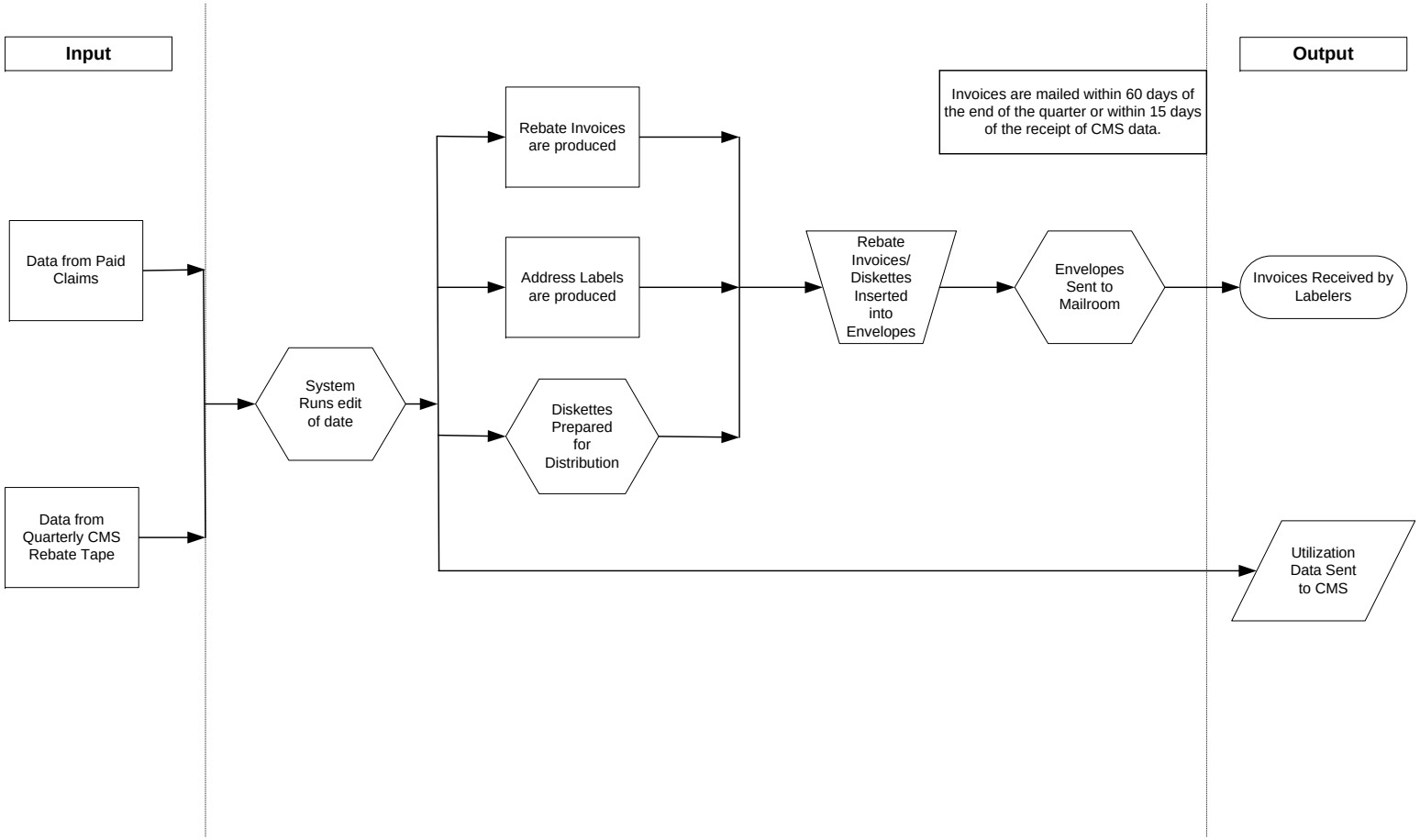
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

7.0 Drug Rebate Accounting

The rebate accounting component is an on-line accounts receivable process that facilitates posting of labeler rebate and interest payments, dispute resolution transactions and quarterly reconciliation activity. The system automatically updates the accounting file for certain types of transactions. These transactions include quarterly invoice billing, PPA adjustments, interest billing and where applicable, state supplemental invoice billing. Other accounting transactions require manual input by First Health. These transactions include rebate and interest payment remittance, dispute resolution adjustments, adjustments taken by labelers without state approval and transferring credits from one quarter to another.

WORKFLOW PROCESS

Drug Application Subsystem: Drug Rebate Accounting



7.1 Maintain Drug Rebate Ledger

All drug rebate activity is tracked through entry of data into the First Rebate system. The First Rebate System consists of two (2) distinct integrated components; invoice generation and rebate accounting.

Invoice Generation

Upon receipt of the quarterly paid claims history, the system runs an edit to exclude certain types of claims from the rebate invoice processing. The units associated with these types of claims are excluded from the rebate invoice utilization totals. The excluded claims are grouped and reported by the system with the quarterly invoice run.

System Edits Out Claims for:

- Claims which are fully paid by a third party payer
- Compound prescriptions, not adjudicated at ingredient level
- Public Health Service Providers
- Invalid NDC numbers (either all "0's" or all "9's")
- Duplicate claims having identical NDC number, date of service, Recipient identification number, prescription number, provider identification number and ICN

Invoice generation is a batch process that edits and merges internal and external data to print invoices and update the accounting file. Each quarter the system merges the consolidated claims from the state's claim processor with the rebate rates from CMS by NDC number. The merge generates drug rebate invoices and updates to the system's Labeler Accounting Master File. Reports are generated with the invoice run that are used for reconciliation purposes.

Procedure

This is an automated task. No manual intervention is needed.

The Rebate Operations staff does a quality check of the invoice generation in a QA environment, prior to the production invoice generation. This ensures that data is accurate and if data is found to be erroneous, corrections can be made prior to the production data being updated.

7.2 Process Cash Receipts

After the invoices have been sent to the labelers, First Rebate receives rebate data from DMAS and posts their payments. First Health personnel will be responsible for entering the amounts and dates of checks returned from the labelers. The cash posting screen in the First Rebate system is used to add, update, or delete checks and batches received. The Cash Posting screen, part of the First Rebate system, is shown below the Procedures. For detailed instructions, see the First Rebate User's Manual in Appendix A.

Procedure

7.3 Maintain Invoice Audit Trails

The Invoice screen in the First Rebate system allows the user to set invoice parameters by invoice threshold amount and provider threshold amount. Using this screen the Rebate staff will be able to maintain invoice audit trails for all labelers. The Invoice screen, part of the First Rebate system, is shown below the Procedures. For detailed instructions, see the First Rebate User's Manual in Appendix A.

Procedure

[redacted]

[redacted]

3. [redacted]

[redacted]

7.4 Process Adjustments

If a labeler disputes the rate or the unit, First Health uses the Adjustment Screen in the First Rebate system to adjust Rates or Units (if a Labeler disputes the invoice total). Labelers are responsible for submitting updated pricing data to CMS to facilitate rebate rate recalculation and forwarding of PPA's to the states. The system derives the Prior Period Adjustment (PPA) from the quarterly CMS rebate data and includes them with the current quarter invoice. The PPA's are separated from the current quarter's invoice and are listed on a separate page per quarter. The system updates the Labeler Accounting File to reflect these changes. For detailed instructions, see the First Rebate User's Manual in Appendix A.

Procedure

[redacted]

5. [redacted].

7.5 Maintain Audit Trails

All data related to the Rebate program is maintained in the First Rebate database. Users can audit any aspect of the program via an extensive series of pre-formatted reports chosen in the First Rebate Web interface. For complete instructions, see the First Rebate Web Reports manual in Appendix B.

The following is a list of Reports used for audit trail purposes.

Category	Report Titles
Audit Reports	▪ Claim Load Audit ▪ Excluded Claims Audit ▪ Invoiced Claims Audit
Management Reports	▪ Current vs Previous Quarter Invoice Comparison ▪ Adjustments By Reason Code ▪ Drug Report For 75% of Total Outstanding Amount Over 12 Months ▪ Dunning Letter ▪ Dunning Notice Report ▪ Executive Summary ▪ J-Code List ▪ J-Code Quarterly List ▪ Labeler Account Balance ▪ Quarterly Labeler Account Balance ▪ Summary of Adjustment by Quarter ▪ Unit Adjustments at NDC Level ▪ Voided Claims
Download Data	▪ Dunning Mailing Labels ▪ Invoice Mailing Labels
Dispute Resolution Reports	▪ Aged Disputes Remaining ▪ Claim Level Detail – Billed Amount 75% Higher than Paid ▪ Claim Level Detail – Quantity Threshold ▪ Claim Level Detail - Unit Cost Less Than $.01 ▪ Claim Level Detail Report (No PHI) ▪ Claim Level Detail Report (With PHI) ▪ Dispute Resolution Log ▪ Outstanding Disputes ▪ PHS Providers
Invoice Cycle Reports	▪ Active Labelers ▪ CMS 64.9R Adjustments ▪ Family Planning Drugs Invoiced

Category	Report Titles
	▪ Family Planning Drugs Payment Received ▪ Interest Received ▪ Invoice Totals for Quarter ▪ Labeler Contact Listings ▪ Labeler Information Sorted Alphabetically ▪ Labeler Paid Amount vs Billed Amount ▪ NDCs With Negative Units ▪ Pre Invoice Unit Adjustments ▪ Quarterly Utilization Summary ▪ Summary of Claims By Group ▪ Terminated Labelers ▪ Threshold Invoice Totals for Quarter.
Rate Information Reports	▪ Analyst Disputed NDC Listing ▪ Disputed NDC's By Labeler By Quarter ▪ Invoice Media ▪ List Rates By Quarter By Labeler ▪ Medicaid Drug Rebate Invoice ▪ NDC Summary ▪ NDC's Not Found on Rate Files ▪ Outstanding Manufacturer Rebate Invoice Balance ▪ Payment Receipt Detail ▪ Prior Period Utilization and Rate Changes ▪ Projected Invoice Amount for Zero Rate NDC'sm Rate Discrepancy ▪ Rebate Amount Exceeds Reimbursement ▪ Summary of Payment ▪ Unit Rebate Amount Received ▪ Zero Rebate Amount Per Unit on Rate File ▪ Zero Rebate Rate for Consecutive Quarters
Receipts Reports	▪ Batch Listing ▪ Cash Receipt Detail ▪ Cash Receipt Recap Support Summary ▪ Manufacturer Receipt Allocations by Labeler ▪ Manufacturer Receipt Allocations by Receipt ▪ Receipt Listings ▪ Receipt Listing By Program ▪ Total Dollars By Check Number

7.6 Support Drug Rebate Audits as Directed by DMAS

The First Health Drug Rebate unit will support any drug rebate audits requested by DMAS or any other agency. The audit should consist of a list of performance measures (totals, dates, etc.) for which the auditors want to see reports. Reports will be specified and produced from the First Rebate Web Reports system.

Procedure

First Rebate Web reports are accessed on the web [redacted]. A full report manual is available upon request.

8.0 Operate the Pro-DUR Help Desk

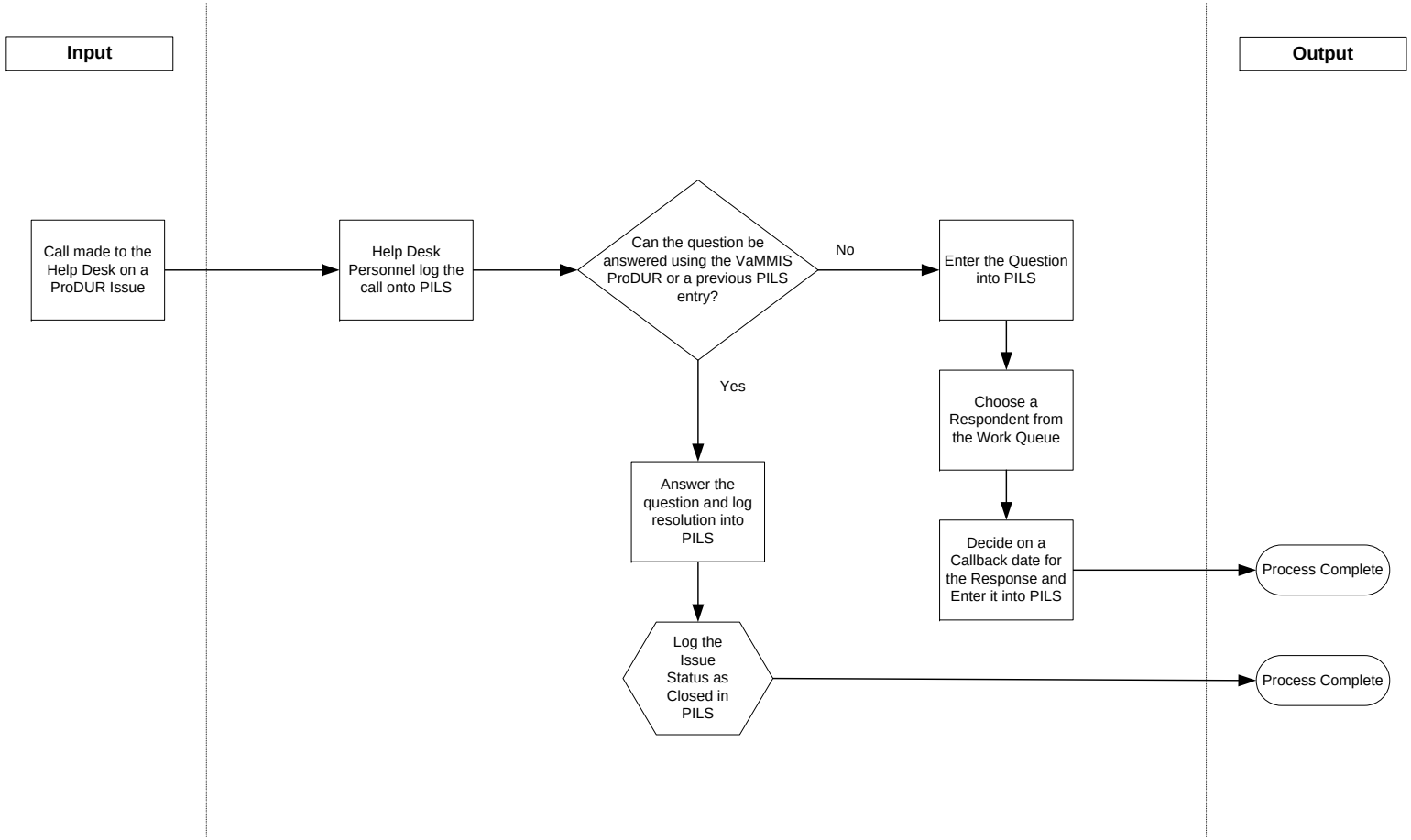
Prospective DUR (ProDUR) saves program dollars and improves patient outcomes by alerting the pharmacist to potentially dangerous therapeutic situations, such as drug-to-drug interactions. Our customizable therapeutic criteria edits allow First Health to adapt the system to meet the needs of special populations, such as the aged.

Prospective Drug Utilization Review inquiries pertain to pre-dispensed drug therapy screening. Pro-DUR screening areas include: Over-utilization, Under-utilization, Excessive Daily Dose, Insufficient Daily Dose, Therapeutic Duplication, Drug to Drug Interaction, Drug-Age Contraindication, Drug-Pregnancy Contraindication, Excessive Quantity, Drug Diagnosis Contraindication. In some cases the Call Center will be responsible for performing overrides on Pro-DUR rejections based on approved criteria established by the client.

The planning, implementation, and management of large-scale pharmacy benefit programs are a hallmark of First Health Services. First Health was the first to design and implement a pharmacy point-of-sale and Drug Utilization Review (DUR) system for Medicaid. Operators at the Pro-DUR help desk will use the PILS system to track calls received and responses to customer inquiries. Operators will access a part of the PILS system used only for Pro-DUR inquiries.

WORKFLOW PROCESS

Drug Application Subsystem: Operate the ProDUR Help Desk



8.1 Receive and Log Help Desk Requests

All Call Center telephone lines are routed through an automatic call distribution (ACD) system that sends the calls, in order of receipt, to the first available Representative. The call management system is monitored constantly by Call Center Management, allowing quick adjustments in workloads and schedules to ensure that performance standards are consistently met. This flexibility also allows additional staff to be hired in anticipation of increased call volumes in order to meet the needs of new clients and clients making program changes.

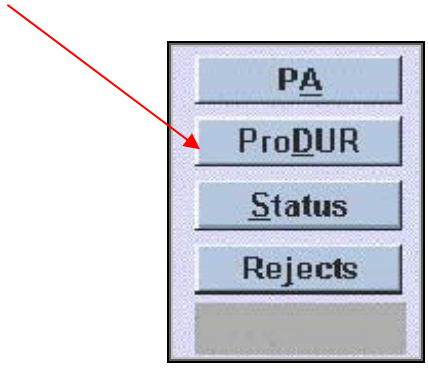
Each call is documented in the on-line call tracking system, which allows for immediate access to complete call information by all CSRs, as well as Call Center management. This system also provides listings of open issues to assist CSRs and management in ensuring that all open issues receive appropriate follow-up. All calls are categorized by issue and allow Call Center management to provide clients with issue-specific information.To use the PILS, you will have to log on to the system. Complete instructions for using PILS, including instructions for accessing a prior contact, adding a new help desk request, and closing out help desk requests are in the PILS user manual in Appendix D.

Procedure

Log on to the PILS system:

1. Enter your ACF2 User ID and Password.
2. You see the PILS main menu.

You can always open the VaMMIS ProDUR series of screens from the main menu or from any screen by choosing the ProDUR button.



8.2 Research and Respond to HELP Desk Requests

The help desk will respond to calls received on ProDUR questions. To adequately answer the client's request, you will access earlier calls logged into the PILS system or open up the ProDUR system of screens to research data there. For complete instructions on using the PILS system and for details of the ProDUR Inquiry screens, see the PILS system user manual in Appendix D and the Online HELP system or the Drug Application User Manual.

Procedure

See Appendix D and the Drug Subsystem User Manual for detailed procedures.

8.3 Document HELP Desk Request Resolution

The Help Desk will track and resolve any issues logged onto the PILS system. Again, see the PILS User Manual in Appendix D for complete instructions and training scenarios.

Procedure

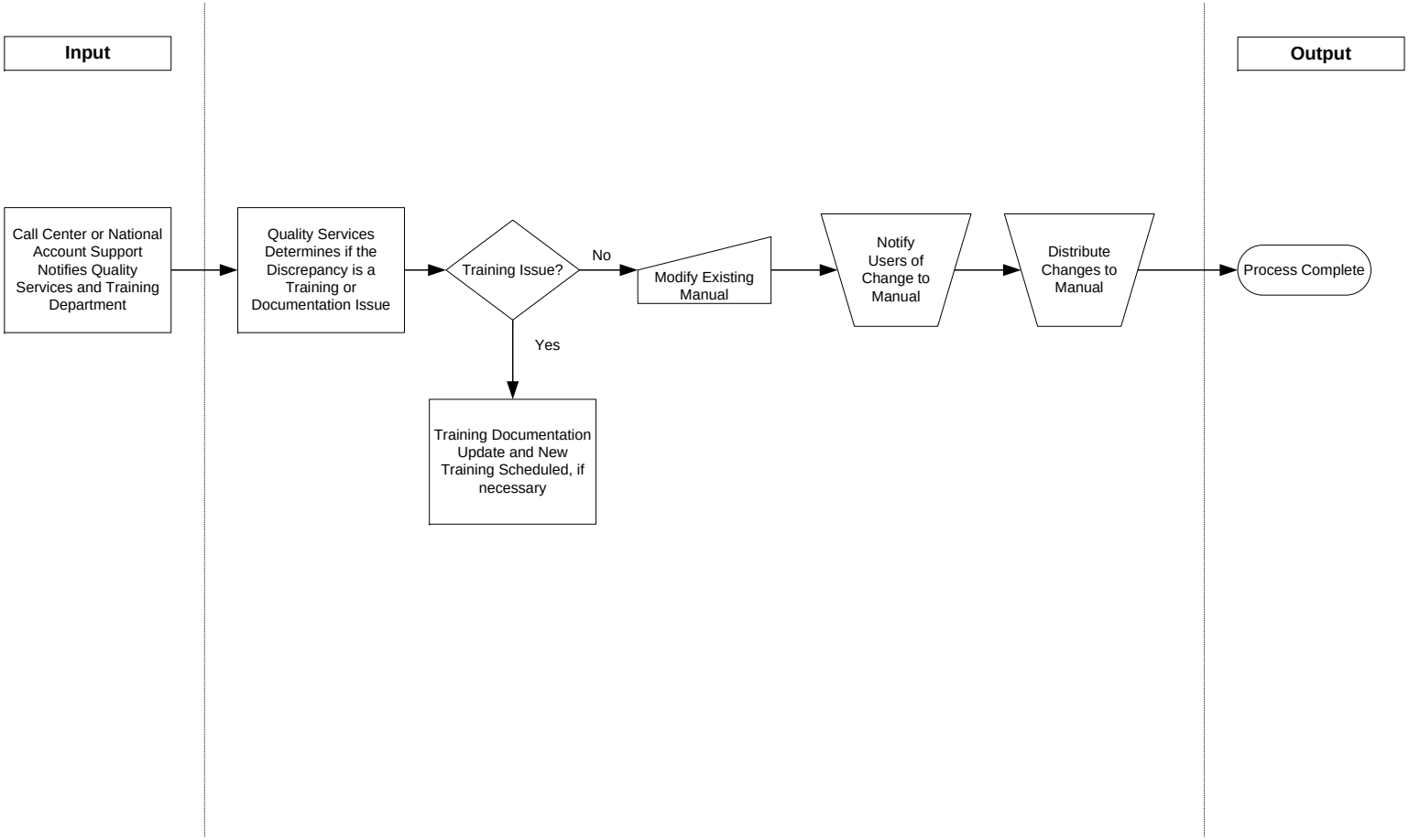
Procedures for documenting HELP desk issue resolution using the PILS system are contained in the PILS User Manual in Appendix D.

9.0 Maintain Pharmacy Unit Manuals and Documentation

The PRN Training group maintains all the training and system documentation for the various systems associated with the Virginia MMIS: First IQ, First Rebate, and the Virginia MMIS. Any changes to the system are only made after the change is evaluated for system impacts and approved for coding.

WORKFLOW PROCESS

Drug Application Subsystem: Maintain Pharmacy Unit Manuals and Documentation



9.1 Maintain Pro-DUR Operations Procedures Manuals

As improvements and updates are made to the Pro-DUR program, the documentation (either on-line) or paper will be updated to reflect the improvement or update to the system. Operations Procedure manuals are changed only when the account manager approves the upgrade or change.

Procedure

1. Identify discrepancy after Call Center or National Account Support notifies Quality Services and Training department.
2. Determine if discrepancy is a training issue or the discrepancy requires modification of the existing manual.
3. Provide specifications of the requested change to systems support.
4. Test and document the change.
5. Get approval of the changes from the account manager or management.
6. Release the updated pages all users.
7. Follow up to ensure that all users read and understand the changes implemented.

9.2 Maintain FirstIQ Operations Procedures Manuals

As improvements and updates are made to any First IQ process, the documentation (either on-line) or paper will be updated to reflect the change in procedure. Operations Procedure manuals are changed only when the account manager approves a draft of the proposed change.

Procedure

1. The owner of First IQ provides specifications of the requested change to system support.
2. System support changes the system.
3. The owner of First IQ and system support are involved in the testing the system.
4. The owner of First IQ identifies discrepancy and notifies the Quality Services and Training Department the manual needs updating.
5. Quality Services and Training Department updates the manual.
6. The owner of FirstIQ approves the FirstIQ manual.
7. The owner of FirstIQ distributes to users.
8. Training Department gets request for training. The manual is distributed to new students.

9.3 Maintain Rebate Procedures Manuals

As improvements and updates are made to the Rebate Procedures, the documentation (either on-line) or paper will be updated to reflect the improvement or update to the system. Rebate Operations Procedure manuals are changed only when the account manager approves the upgrade or change.

Procedure

1. The owner of First Rebate provides specifications of the requested change to system support.
2. System support changes the system.
3. The owner of First Rebate and system support are involved in the testing the system.
4. The owner of First Rebate identifies discrepancy and notifies the Quality Services and Training Department the manual needs updating.
5. Quality Services and Training Department updates the manual.
6. The owner of First Rebate approves the First Rebate manual.
7. The owner of First Rebate distributes to users.

9.4 Maintain POS HELP Desk Edit Manuals

The POS Help desk relies on the Quikchek system to give operators access to timely, correct information with which to answer client's questions. The procedure for updating Quickchek is detailed below:

Procedure

Errors are identified and forwarded from two sources:

Sr. Account Support Analyst: E-mails changes that impact the client's documentation to the technical writer.

Call Center: Finds errors in the Quickchek and emails to the technical writer.

Technical Writer, QC/Training Department

1. Revises supporting documentation (Quick Check, Provider Manual, and CSA) with additional support from the Pharmacy Plan Administration Department
2. Consult the call center on the wording of the change for the Quickchek.
3. Revise dates.

4. Revises the Benefit Changes form for the Quickchek, and other supporting documents that are impacted.
5. E-mails team leaders of call center, QA/Training Department, and Administrative Assistance that are on the distribution list of the coming changes.
6. Delivers updated copies of Quickchek to call center representatives.

9.5 Maintain Claims HELP Desk Procedures Manuals

HELP Desk Procedures are maintained by the Phramacy QC/Training Department. Any change in procedure will have the approval of the account manager and the help desk supervisor.

Procedure

1. Client requests update.
2. System support changes the system.
3. The owner of application and system support are involved in the testing the system.
4. The owner of application identifies discrepancy and notifies the Quality Services and Training Department the manual needs updating.
5. Quality Services and Training Department updates the manual.
6. Client approves the manual.
7. Quality Services and Training Department sends the manual to the client.

   Note: Not every client has a Help Desk Procedures Manual. It is created by client request.

Maintain QuikChek Procedures

The QuikChek is a client overviews document that the Call Centers use to answer the calls from Providers in regards to pharmacy benefit management issues. It is updated frequency. In order to update the QuikChek, the request usually comes from the Plan Administration department.

1. Client requests a change.
2. Plan Administration makes the change.
3. Plan Administration checks and tests the system.
4. Plan Administration sends an email to the Quality Services and Training Department.
5. Quality Services and Training Department with the help of the Plan Administration and sometimes the Call Center, updates the QuikChek.

6. QuikChek is distributed and posted on the intranet for the Call Center.
7. If call center requests training, the Training Department will have a class.